

FILED DEC 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45363

STATE FILE NUMBER

Registration District No. 282 Primary Registration District No. 4424 Registrar's No. 132

1. PLACE OF DEATH a. COUNTY Polk		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cedar	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Humansville		c. CITY OR TOWN Dunnegan	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Geo. Dimmitt		Length of stay in 1b 33 hrs.	
d. STREET ADDRESS R. 1		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mem. Hogan James Emmett Rains		4. DATE OF DEATH Month 12 Day 2 Year 57	
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/1897
9. AGE (In years last birthday) 60		IF UNDER 1 YEAR Months 0 Days 20 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) Cedar County, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James B. Rains		14. MOTHER'S MAIDEN NAME Mary Ellen Garrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT J. E. Rains, Kansas City, Mo.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE-(a) Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) multiple Fractures of Skull- DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 30 hrs			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 3:30 Month 11 Day 30 Year 57 a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Street	
20f. CITY, TOWN, OR LOCATION Humansville, Mo.		COUNTY Polk STATE Mo.	
21. I attended the deceased from 11/30/57 to 12/2/57 and last saw him alive on 12/1/57 Death occurred at 1:10 A. M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE H. H. Robinson (Degree or title) M. D.		22b. ADDRESS Humansville, Mo.	
22c. DATE SIGNED 12/10/57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/4/57	
23c. NAME OF CEMETERY OR CREMATORY Alder Cemetery		23d. LOCATION (City/town or county) (State) Cedar County, Missouri	
24. FUNERAL DIRECTOR Beckwith Funeral Home, Humansville, Mo.		25. DATE RECD. BY LOCAL REG. 12-11-57	
26. REGISTRAR'S SIGNATURE Ralph Gordon per Jewell Gordon			

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision..

Student _____
Signature of Student Embalmer

Signed O. H. Beckwith

Licensed Embalmer No. 3927

P. O. Address Humansville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.